

Medical Records Release Request

Please release any medical records regarding:

Patient Name _____

Date of Birth _____

Address _____

To:

University Imaging
246 Hamburg Turnpike
Suite 101
Wayne, NJ 07470
Tel: 973.942.2266
Fax: 973.942.1171

Signature _____ Date _____

Witness: _____ Date _____

Name and address of Physician and/or Hospital that records are being obtained from:

